**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

KAREN ASBURY, MD
PO BOX 121589
ARLINGTON, TX 76012

**Respondent Name**

OLD REPUBLIC INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 44

**MFDR Tracking Number**

M4-10-3384-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "NOT PAID PER THE DWC FEE GUIDELINES"

**Amount in Dispute:** $115.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** A copy of dispute was placed in carrier rep box on March 30, 2010 with no response to MFDR.

**Response Submitted by:** NA

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 13, 2009 | 99456-W5-26, 99456-W5-TC, and 99080-73 | $115.00 | $100.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 15, 2009
   - 147 – Provider contracted/negotiated rate expired or not on file.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable. Reimbursement methodology.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

   Explanation of benefits dated January 14, 2010
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

**Issues**

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is CPT code 99080-73 included in the payment for the Return to Work (RTW) examination?
3. Is the requestor entitled to reimbursement?

**Findings**

1. The provider billed the amount of $800.00 for CPT code 99456-W5-26 for the professional component of Maximum Medical Improvement/Impairment Rating (MMI/IR) as a DD. The provider also billed the amount of $800.00 for CPT code 99456-W5-TC for the technical component of MMI/IR examination. Documentation supports that the MMI determination is payable at $350.00. For the IR, methods of calculating IR and the number of body areas determine reimbursement. Documentation supports that MMI was assigned and two body areas were rated. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on the cervicothoracic (spinal region) is $150.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on left shoulder (upper extremities) is $300.00. 28 Texas Administrative Code §134.204 states in part (j)(4)(C)(iv) and (v):

   > (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.
   >
   > (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

2. Regarding CPT code 99080-73, which is billed with the 99456-W8-RE Return to Work (RTW) exam which was paid and not in dispute, 28 Texas Administrative Code §134.204 states in part (k) that reimbursement

   "shall include Division-required reports." Therefore, reimbursement is bundled and no separate reimbursement is recommended for the report charge.

3. Review of the Division rules above show that the combined MAR for the MMI/IR exam is $800.00. Respondent has already paid $560.00 for the CPT 99456-W5-26 and $140.00 for CPT 99456-W5-TC which totals $700.00. An additional amount of $100.00 is recommended for reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $100.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $100.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | November 1, 2011 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.